

## **PROVIDER CERTIFICATION/AGREEMENT/REASSIGNMENT OF PAYMENT For Providers of School-Based Health Services**

Under Federal regulations, in order for a supervisory union to bill Medicaid for services furnished by a provider who is under contract or agreement with the supervisory union, the provider must (1) meet Medicaid provider qualifications, (2) have a Provider Agreement with the State Medicaid Agency, and (3) reassign his/her right to Medicaid Payment for such services to the supervisory union.

### Provider Qualifications

I, \_\_\_\_\_  
Name Title

certify that I am: (Please check all that apply)

- \_\_\_\_\_ Currently enrolled as a Medicaid Provider ( Provider # \_\_\_\_\_ )  
Sign Section A on reverse.
- \_\_\_\_\_ Licensed by the State of Vermont (Please attach a copy of license.)  
Sign Section B on reverse.
- \_\_\_\_\_ Certified by the Vermont Department of Education (Please attach a copy of certification)  
Sign Section B on reverse.
- \_\_\_\_\_ A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association. (Please attach a copy of the degree).  
Sign Section B on reverse.
- \_\_\_\_\_ Have a Certificate of Clinical Competence from the American Speech and Hearing Association or the equivalent education and work experience to qualify for such Certification. (Please attach a copy of the Certificate or proof of qualifications.)  
Sign Section B on reverse.
- \_\_\_\_\_ Registered by the American Occupational Therapy Association. (Please attach a copy of Registration.)  
Sign Section B on reverse.
- \_\_\_\_\_ Have a Master's Degree from an accredited School of Social Work. (Please attach a copy of the Degree.)  
Sign Section B on reverse.
- \_\_\_\_\_ Other Qualifications: (Please specify)  
Sign Section B on reverse.
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(over)

## A. Reassignment of Payment

I hereby voluntarily reassign my right to payment from the Medicaid agency for services I provide to students under my agreement with the \_\_\_\_\_ Supervisory Union.

\_\_\_\_\_  
Signature of Provider

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervisory Union Representative

\_\_\_\_\_  
Date

## B. This section applies to providers not otherwise enrolled in the Medicaid Program.

As a condition for providing services to Medicaid eligible children I agree to the following:

1. To conform to all applicable Federal and State laws and regulations.
2. To offer services in accordance with Title VI of the 1964 Civil Rights Act and Section 504 of the Rehabilitation Act of 1973, as amended.
3. To keep such medical, case or business records as are necessary to fully document the extent of services provided and to furnish these records to the State Medicaid Provider Fraud Unit of the Office of the Vermont Attorney General, if requested to do so.

I understand that this Provider Agreement does not allow me to bill Medicaid directly for Services I may furnish to Medicaid recipients.

\_\_\_\_\_  
Signature of Provider

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervisory Union Representative

\_\_\_\_\_  
Date